# Louisiana Department of Health Confidential Report of Sexually Transmitted Diseases (STD)

**PROVIDER INFORMATION**

| | | | | | |
|---|---|---|---|---|---|
| Name of Provider: | | Phone: ( ) - | | Fax Number: ( ) - | |
| Facility Name: | | Email: | | | |
| Address: | City: | | State: | Zip | |
| Name of Person Reporting: | | Position: | | | |

**PATIENT INFORMATION**

| | | | | | |
|---|---|---|---|---|---|
| Patient Medical Rec. #: | | Insurance : | ☐ Private ☐ Medicaid ☐ Unknown ☐ None | | |
| First Name: | Middle Initial: | Last Name: | | | |
| Address: | City: | | State: | Zip | |
| Patient Hm Ph: ( ) - | Patient Wk Ph: ( ) - | | Patient Cell Ph: ( ) - | | |
| DOB (MM/DD/YYYY) / / | SSN: - - | | Emergency Contact: | | |

Sex at Birth: ☐ Male ☐Female

Gender: ☐Male ☐ Female ☐ Transgender Male-to-Female ☐ Transgender Female-to Male

Pregnant: ☐ Yes, Expected Delivery Date: / / ☐ No ☐ Unknown

Race: ☐ White ☐ Black ☐Asian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Other/Unknown

Ethnicity: ☐ Hispanic ☐Non- Hispanic

Marital Status: ☐ Single ☐ Married ☐ Partner ☐Divorced ☐Widowed

Gender of Partner(s): ☐ Male ☐ Female ☐ Transgender Male-to-Female ☐ Transgender Female-to-Male ☐ Unknown

## CHLAMYDIA

☐ Urogenital (Urine, cervical, etc.)
☐ Oral/ Pharyngeal
☐ Rectal
☐ Ophthalmia neonatorum
☐ Proctitis
☐ Pelvic Inflammatory Disease (PID)
☐ Pneumonia
☐ Other (specify): _____

**Date of Specimen Collection:**
**_____/_____/_____**

**Test(s)Conducted:**
☐ Culture
☐ NAAT
☐ Nucleic Acid Probe
☐ Point of Care Test
☐ Other (specify): _____

**Date Treatment Administered:**
**_____/_____/_____**
**Date of prescription given:**
**_____/_____/_____**

**Recommended Treatment:**
☐ Azithromycin 1g orally in a single dose
**OR** Doxycycline 100 orally 2x/day for 7 days

**Alternative:**
☐ Erythromycin base 500 mg orally 4x/day for 7days
**OR** Erythoromycin ethylsuccinate 800 mg orally 4x/day for 7days
**OR** Levofloxacin 500 mg orally 1x/day for 7 days
**OR** Ofloxacin 300mg orally 2x/day for 7 days

**If Pregnant :**
☐ Azithromycin 1 g orally in a single dose
☐ Amoxicillin 500 mg orally 3x/day for 7 days
**OR** Erythromycin base 500mg orally 4x/day for 7 days
**OR** Erythromycin base 250 mg orally 4x/day for 14 days
**OR** Erythromycin ethylsuccinate 800 mg orally 4x/day for 7 days
**OR** Erythromycin ethylsuccinate 800 mg orally 4x/day for 14 days

**Name of Testing Laboratory:**

## GONORRHEA

☐ Urogenital (Urine, cervical, etc.)
☐ Oral/Pharyngeal
☐ Rectal
☐ Disseminated Gonococcal Infection (DGI)
☐ Ophthalmia neonatorum
☐ Resistant Strain
☐ Proctitis
☐ Pelvic Inflammatory Disease (PID)
☐ Other (specify): _____

**Date of Specimen Collection:**
**_____/_____/_____**

**Test(s)Conducted:**
☐ Culture
☐ NAAT
☐ Nucleic Acid Probe
☐ Point of Care Test
☐ Other (specify): _____

**Date Treatment Administered:**
**_____/_____/_____**
**Date of prescription given:**
**_____/_____/_____**

**Recommended Treatment:**
☐ **Dual** therapy with Ceftriaxone 250 mg IM in a single dose
**PLUS** Azithromycin 1 g orally in a single dose or Doxycycline 100 mg orally twice a day for 7 days

**Alternatives (*Note - Only if Ceftriaxone is not available)**
☐ **Dual therapy** with Cefixime 400 mg orally **PLUS** Azithromycin 1g Orally or Doxycycline 100 mg orally twice a day for 7 days

**If cephalosporin allergic:**
☐ Gemifloxacin 320 mg orally **PLUS** Azithromycin 2 g orally
**OR** Gentamicin 240 mg IM **PLUS** Azithromycin 2 g orally

**Name of Testing Laboratory:**

## SYPHILIS

**NOTE: Call to report [(504) 568-7474], then follow-up with form**
☐ Primary (Genital or oral ulcer)
☐ Secondary (Rashes)
☐ Early non-primary non-secondary
☐ Unknown duration or Late syphilis
☐ Tertiary –Cardiovascular
☐ Tertiary- Neurosyphilis
☐ Congenital
☐ Other_____

**Date of Specimen Collection:**
**_____/_____/_____**

**Test(s) Conducted & Results:**
☐ RPR Titer _____
☐ VDRL Titer _____
☐ MHATP _____
☐ FTA _____
☐ IgG (EIA) _____
☐ TP-PA _____
☐ Other _____

**Recommended Treatment:**
☐ 2.4 million units Benzathine Penicillin G (BIC) IM X 1 dose
**Date Administered: _____/_____/_____**

☐ 2.4 million units Benzathine Penicillin G (BIC) IM X 3 doses
**Date 1st Dose Administered: _____/_____/_____**

☐ Doxycycline 100 mg orally twice a day for 14 days
☐ Doxycycline 100 mg orally twice a day for 28 days
☐ Other: _____

**Date prescription given: _____/_____/_____**

**Name of Testing Laboratory:**

## OTHER

☐ Herpes Simplex Virus (Neonates)
☐ Other (specify): _____

**Date of Specimen Collection:**
**_____/_____/_____**

**Test(s) Conducted & Results:**
☐_____
☐_____
☐_____

**Treatment:**
☐_____
☐_____

**Name of Testing Laboratory:**

**Mail or FAX form to: Louisiana Department of Health-STD/HIV Program, PO Box 60630, New Orleans, LA 70160; (504)568-8384.**
For more information call (504) 568-7474 or go to http://www.LAHHUB.org (Form: STD 43 Rev 4/2/18)

**LOUISIANA DEPARTMENT OF HEALTH CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED DISEASES (STD)**
Form: STD 43 Revised April 2, 2018 (updates reflect new 2018 CDC syphilis case definitions)

DESCRIPTION & PURPOSE
The STD 43 is a single page form to report newly diagnosed, re-infected, and treated STDs with the exception of HIV/AIDS.

Directions for reporting HIV/AIDS cases contact: STD/HIV Program, 1450 Poydras Street Suite 2136, New Orleans, LA 70112, (504)568-7474. For information about HIV/AIDS Surveillance: http://ldh.la.gov/assets/oph/Center-PHCH/Center-PH/tuber/LouisianaAdministrativeCodeTitle51PublicHealthSanitaryCodeJan2010.pdf

INSTRUCTIONS FOR COMPLETING STD 43: CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED DISEASES
Use one (1) form per person to report all applicable STDs. Print legibly.

Provider Information: Write the Name, Addresses, Phone number and Name of Person Reporting in the box or place a typed label with the same information over the box. If provider and facility are different, provide information for both. Services provided via the internet must list a valid medical provider and facility name.

Patient Information: Write the medical record #, First/Middle Initial/Last Name, Type of Insurance used for visit, Address, City/State/Zip Code, Phone number(s), Date of Birth (DOB), Social Security Number (SSN), in the spaces provided. Check the appropriate box (es) for Sex at Birth, Gender, Pregnancy status, Marital status, Race, Ethnicity, and Gender of Partner(s).

Disease: Check appropriate box (es) in this section depending on the diagnosis. In addition to completing the form, call the STD/HIV Program at (504)568-7474 to report all cases of primary & secondary syphilis.

For each disease reported complete each box in the appropriate column including:

1. Check the box (es) for the disease(s) being reported
2. Write the date laboratory specimens were collected
3. Write the name of the laboratory where tests were conducted
4. Check the box (es) for type of test(s) conducted that were positive. Syphilis test(s) conducted must be reported with results to identify new cases:
   - If RPR/VDRL is positive and confirmatory test (e.g., TPPA or lgG-EIA) is negative, report NEGATIVE confirmatory test result also (to validate biological false positives).
   - Enter titer result for the RPR and/or VDRL test (e.g., RPR 1:16, VDRL 1:128).
   - Report non-reactive/negative RPR/VDRL result if confirmatory test is positive (i.e. TPPA, lgG-EIA, FTA, etc.)
5. Write / check box (es) of medication given; write date treatment was administered and prescription was provided

Important Note:
Form STD 43 should be mailed to the STD/HIV Program as soon as the diagnosis is made. The form may be filled before treatment is completed. Patients should not be reported as cases unless the diagnosis is confirmed by appropriate tests. All contacts of STDs should be tested for the disease(s) to which they were exposed. If contacts are treated in the absence of positive laboratory tests, then they are considered epidemiologically treated. Epidemiologic treatment is applicable only to persons exposed to known STD cases. Therefore, the term does not apply to persons who are treated for symptoms only and are not, therefore, definitively diagnosed. Reporting of epidemiologic treatment should be withheld and reported only with positive laboratory tests.

MAIL or FAX FORM TO:
LOUISIANA DEPARTMENT OF HEALTH- STD/HIV Program
1450 Poydras Street Suite 2136
New Orleans, LA 70112

Or

PO BOX 60630
NEW ORLEANS LA 70160

FAX to: (504)568-8384

For questions contact the STD/HIV Program at: 504-568-7474 or visit our web site at: http://www.LAHHUB.org.